

STATEMENT OF PRIVACY PRACTICES

Leo J. Rosenthal, DDS, PC
6100 Franconia Road, Suite A

Alexandra, Virginia
Office: 703-922-8440
FAX: 703-922-8443

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voice mail messages, answering machines, and postcards.

Patient Rights

You have the right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Leo J. Rosenthal, DDS, PC
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Alexandria, Virginia 22310
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Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Leo J. Rosenthal, DDS, PC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Leo J. Rosenthal, DDS, PC reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY		
In addition to the allowable disclosures in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.		
ANY MEMBER OF MY IMMEDIATE FAMILY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SPOUSE ONLY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OTHER(PLEASE SPECIFY)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representatives Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED		
PROVIDED PRIOR TO TREATMENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
REASON FOR DENIAL		
<input type="checkbox"/> NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES		
<input type="checkbox"/> WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING		
<input type="checkbox"/> UNABLE TO SIGN.		
<input type="checkbox"/> REASON NOT GIVEN.		
<input type="checkbox"/> OTHER: (EXPLAIN)		

LEO J. ROSENTHAL,DDS,PC

NAME (PATIENT)	ADDRESS	ZIP CODE
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SOCIAL SECURITY#	DATE OF BIRTH	AGE	MARITAL STATUS
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HOME PHONE	WORK PHONE	CELL PHONE	EMPLOYER
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NAME OF SPOUSE OR PARENT IF PATIENT IS A MINOR

SPOUSE EMPLOYER	ADDRESS	WORK PHONE
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DENTAL INSURANCE CO.	INS. CO. ADDRESS	GROUP#
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PHYSICIAN + PHONE NO.	DATE OF LAST MEDICAL EXAM
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LIST OF CURRENT MEDICATIONS

DRUG ALLERGIES

DO YOU HAVE ANY HEALTH PROBLEMS? IF SO , PLEASE LIST:-----

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE?	YES	NO
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HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST TWO YEARS?	YES	NO
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ARE YOU HIV POSITIVE? (AIDS)	YES	NO
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ARE YOU TAKING BIRTH CONTROL PILLS?	YES	NO
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HAVE YOU EVER TAKEN FEN-FEN FOR WEIGHT LOSS	YES	NO
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HAVE YOU EVER HAD OR CURRENTLY HAVE:

HEART PROBLEM	YES	NO	RHEUMATISM	YES	NO
ARTHRITIS	YES	NO	LUNG PROBLEM	YES	NO
DIABETES	YES	NO	RHEUMATIC FEVER	YES	NO
EPILEPSY	YES	NO	HIGH BLOOD PRES SURE	YES	NO
EAR PROBLEMS	YES	NO	NERVOUS PROBLEM	YES	NO
FAINTING SPELLS	YES	NO	PROLONGED BLEEDING	YES	NO
HEPATITIS	YES	NO			

SIGNATURE OF RESPONSIBLE PARTY:

DATE:

Financial Assignment and Agreement

Please be advised that this office is not responsible for knowing each patients insurance benefits. Your arrangement with the insurance company is between you and your insurance carrier.

It is the patient's responsibility to be familiar with their individual plan. If you need to know whether or not a recommended procedure is covered by your insurance company, please ask this office to pre-authorize the treatment.

I certify that I have read the information contained in this financial form and agree to the terms listed. I also agree to pay all cost of collections and attorney fees in an amount equal to one-third of the balance due on the account.

At a point of default, interest will accrue at 18% per annum. There will be a \$25.00 fee assessed on all returned checks.

Effective January 1, 2007, Dr. Rosenthal will be considered an out-of-network provider for all insurance plans. Dr. Rosenthal will continue to file all necessary paperwork to insurance companies so they may reimburse the patient.

Payment will be due from the patient at the time of service unless prior financial arrangements have been made.

Signed (Patient or Parent if minor) _____ Date _____